STATE OF MICHIGAN

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Before the Director of the Department of Insurance and Financial Services

In the matter of:

Best Care Nursing Services
Petitioner **File No. 21-1467**

v

Progressive Michigan Insurance Company
Respondent

Issued and entered
this 19th day of January 2022
by Sarah Wohlford
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On September 23, 2021, Best Care Nursing Services (Petitioner) filed with the Department of Insurance and Financial Services (Department) a request for an appeal pursuant to Section 3157a of the Insurance Code of 1956 (Code), 1956 PA 218, MCL 500.3157a. The request for an appeal concerns the determination of Progressive Michigan Insurance Company (Respondent) that the cost of treatment, products, services, or accommodations that the Petitioner rendered was inappropriate under Chapter 31 of the Code, MCL 500.3101 to MCL 500.3179.

The Petitioner's appeal is based on the denial of a bill pursuant to R 500.64(3), which allows a provider to appeal to the Department from the denial of a provider's bill. The Respondent issued the Petitioner bill denials on September 10 and 16, 2021. The Petitioner now seeks reimbursement in the full amount it billed for the dates of service at issue.

The Department accepted the request for an appeal on October 15, 2021. Pursuant to R 500.65, the Department notified the Respondent and the injured person of the Petitioner's request for an appeal on October 15, 2021 and provided the Respondent with a copy of the Petitioner's submitted documents. The Respondent filed a reply to the Petitioner's appeal on November 5, 2021.

II. FACTUAL BACKGROUND

This appeal concerns the appropriate reimbursement amount for home health aide services and nursing care services rendered on 9 dates of service[1] under Healthcare Common Procedural Coding System (HCPCS) Level II codes G0493, G0156, and G0156 with a TG modifier. These procedure codes are described as skilled services of a registered nurse, each 15 minutes; home health aide, in a home or hospice setting, each 15 minutes; and the TG modifier describes complex/high level of care, respectively.

With its appeal request, the Petitioner's submitted documentation which included two *Explanation of Review* letters issued by the Respondent and a narrative outlining its reason for appeal. The Petitioner stated in its narrative that the Respondent "short paid invoices in the amount of $[redacted] per hour for nursing care and $[redacted] per hour for aides." In addition, the Petitioner stated:

> According to the DIFS No -Fault Fee Schedule, R 500.203 Medicare Calculation, Rule 3, when calculating the amount payable to a provider for a service under Medicare part A or B, as referenced in section 3157 of the act, MCI 500.3157, the amounts payable to participating providers under the applicable fee schedule shall be utilized. An amount payable pursuant to the fee schedule may not exceed the average amount charged by the provider for service on January 1, 2019…we have met the criteria for NOT receiving a 45% reduction. We have used a Medicare billing code with a fee schedule attached, we have sent our 2019 chargemaster. 2019 rates can easily be verified by the [Respondent] since this is an established case between us for several years.

In its denials, the Respondent stated that the Petitioner's charge for services rendered were calculated at an allowed amount of $[redacted] per visit for nursing care and $[redacted] per hour for nurse aide care. In its reply, the Respondent stated that it correctly issued payment to the Petitioner under MCL 500.3157(7)(i). Specifically, the Respondent stated:

> The at-issue rate change went into effect as of July 1, 2021. To be clear, Medicare does NOT pay for 24 hour a day care at home, which is the majority of what is being billed in this claim. That can be confirmed at the following Medicare website: https://www.medicare.gov/coverage/home-health-services. As such, pursuant to MCL 500.3157(7)(i), when "Medicare does not provide an amount payable for a treatment...For treatment or training rendered after July 1, 2021 and before July 2, 2022", 55%." DIFS issued bulletin 2021-16INS, which stated that benefits payable under MCL 500.3157(7) shall be increased by 4.11% for that same time period.

[1] The dates of service at issue are July 6 and 7, 2021 under procedure code G0156; July 13, 15, 20, and 21, 2021 under procedure coder G0156 with a TG modifier; and July 9 and 24, 2021, and August 17, 2021, under procedure code G0493.

On October 15, 2021, the Department requested that the Petitioner submit its charge description master (CDM). See MCL 500.3517(7). The Petitioner submitted its CDM to the Department the same day.[2]

III. ANALYSIS

Director's Review

Under MCL 500.3157a(5), a provider may appeal an insurer's determination that the provider overutilized or otherwise rendered inappropriate treatment, products, services, or accommodations, or that the cost of the treatment, products, services, or accommodations was inappropriate under Chapter 31 of the Code. This appeal involves a dispute regarding cost.

For dates of service after July 1, 2021, MCL 500.3157 governs the appropriate cost of treatment and training. Under that section, a provider may charge a reasonable amount, which must not exceed the amount the provider customarily charges for like treatment or training in cases that do not involve insurance. Further, a provider is not eligible for payment or reimbursement for more than specified amounts. For treatment or training that has an amount payable to the person under Medicare, the specified amount is based on the amount payable to the person under Medicare. If Medicare does not provide an amount payable for a treatment or rehabilitative occupational training under MCL 500.3157(2) through (6), the provider is not eligible for payment or reimbursement of more than a specified percentage of the provider's charge description master in effect on January 1, 2019 or, if the provider did not have a charge description master on that date, an applicable percentage of the average amount the provider charged for the treatment on January 1, 2019. Reimbursement amounts under MCL 500.3157(2), (3), (5), or (6) may not exceed the average amount charged by the provider for the treatment or training on January 1, 2019. See MCL 500.3157(8); MAC R 500.203.

MCL 500.3157(15)(f) defines "Medicare" as "fee for service payments under part A, B, or D of the federal Medicare program established under subchapter XVIII of the social security act, 42 USC 1395 to 1395lll, without regard to the limitations unrelated to the rates in the fee schedule such as limitation or supplemental payments related to utilization, readmissions, recaptures, bad debt adjustments, or sequestration." Under MAC R 500.203, reimbursements payable to providers are calculated according to "amounts payable to participating providers under the applicable fee schedule." "Fee schedule" is defined by MAC R 500.201(h) as "the Medicare fee schedule or prospective payment system in effect on March 1 of the service year in which the service is rendered and for the area in which the service was rendered." Accordingly, reimbursement to providers under MCL 500.3157 is calculated either on a fee schedule (i.e., fee-for-service) basis or on a prospective payment system basis.

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[2] The CDM the Petitioner submitted to the Department upon request listed variable amounts for G0156-TG. The Department requested the Petitioner submit documentation in the form of bills and reimbursements from insurers to support an average amount charged on January 1, 2019. The supporting documentation showed that the Petitioner charged $[redacted] per hour for high tech aides with a TG modifier appended. The Department then divided by 4 to calculate the 15 minutes increments billed, resulting in a calculation of $[redacted] per unit.

HCPCS Level II Codes G0438 and G0156 with and without a TG modifier have amounts payable under Medicare when they are billed on a prospective payment system basis. No payment amount is available for HCPCS Level II Codes G0438 and G0156 under on a fee-schedule basis because those codes are not priced separately. Where there is no amount payable under Medicare, reimbursement is calculated based on a provider's charge description master or average amount charged on January 1, 2019. See MCL 500.3157(7).

To calculate the appropriate reimbursement amount, the Department relied on the Petitioner's submitted CDM as of January 1, 2019 for G0156 and G0493 and the Petitioner's 2019 average amount charged for G0156 with modifier TG. Pursuant to MCL 500.3157(7), the amount payable to the Petitioner for the procedure codes at issue for are $[redacted] per unit for G0156, $[redacted] per unit for G0156 with a TG modifier, and $[redacted] per unit for G0493.

HCPCS code	January 1, 2019 CDM amount	55% of January 1, 2019 CDM amount	4.11% CPI Adjustment	Amount payable for the dates of service at issue
G0493	$[redacted]	$[redacted]	$[redacted]	$[redacted]/unit
G0156	$[redacted]	$[redacted]	$[redacted]	$[redacted]/unit
HCPCS code	**January 1, 2019 average amount charged**	**55% of January 1, 2019 average amount charged**	**4.11% CPI adjustment**	**Amount payable for the dates of service at issue**
G0156-TG	$[redacted]	$[redacted]	$[redacted]	$[redacted]/unit

Accordingly, the Department concludes that the Petitioner is entitled to additional reimbursement for the July 13, 15, 20, and 21, 2021 dates of service under procedure code G0156 with modifier TG. The Petitioner is not entitled to additional reimbursement for the remaining dates of service at issue for procedure codes G0493 and G0156 without a modifier.

IV. ORDER

The Director reverses, in part, the Respondent's determination dated September 10, 2021 that the cost of the treatment for the July 13, 15, 20, and 21, 2021 dates of service under procedure code G0156 with modifier a TG was inappropriate under Chapter 31 of the Code, MCL 500.3101 to MCL 500.3179. The Director upholds Respondent's determinations dated September 10 and 16, 2021 not to reimburse the Petitioner for the full amount charged for treatments rendered on July 6 and 7, 2021 under procedure code G0156, and July 9 and 24, 2021, and August 17, 2021 under procedure code G0493.

The Petitioner is entitled to reimbursement in the amount payable under MCL 500.3157 for the July 13, 15, 20, and 21, 2021 dates of service for procedure code G0156 with modifier TG discussed herein,

and to interest on any overdue payments as set forth in Section 3142 of the Code, MCL 500.3142. R 500.65(6). The Respondent shall, within 21 days of this order, submit proof that it has complied with this order

This order applies only to the treatment and dates of service discussed herein and may not be relied upon by either party to determine the injured person's eligibility for future treatment or as a basis for action on other treatment or dates of service not addressed in this order.

This is a final decision of an administrative agency. A person aggrieved by this order may seek judicial review in a manner provided under Chapter 6 of the Administrative Procedures Act of 1969, 1969 PA 306, MCL 24.301 to 24.306. MCL 500.244(1); R 500.65(7). A copy of a petition for judicial review should be sent to the Department of Insurance and Financial Services, Office of Research, Rules, and Appeals, Post Office Box 30220, Lansing, MI 48909-7720.

Anita G. Fox
Director
For the Director:

X Sarah Wohlford

Sarah Wohlford
Special Deputy Director
Signed by: Sarah Wohlford